

Safe staffing levels – a national imperative

The UK nursing labour market review 2013



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1. Introduction

This report is the 2013 annual review of the UK nursing labour market commissioned by the Royal College of Nursing. In the 12 months since the last labour market review (LMR) was published, there have been several key events that have deep and far-reaching implications for the nursing workforce. In combination, these events point to the urgent need to address both the national security of the supply of nurses, and the local ability to determine evidence-based nurse staffing levels.

The Francis report

The Francis report on care quality at the Mid Staffordshire NHS Foundation Trust published in early 2013 marks a watershed for the NHS¹. Published in response to concerns about high mortality rates and poor governance at the Mid Staffordshire NHS Foundation Trust, the report made a broad range of recommendations covering local and national NHS management, governance, quality assurance and staffing. One clear message from the report is that there is a need for a more systematic and responsive approach to determining nurse staffing levels. The RCN in its response to the Francis report stated: “The RCN fully supports the recommendations to develop national standards for the development, maintenance and reporting of safe staffing levels in the NHS.”² It also noted that the Care Quality Commission (CQC) had found that 16 per cent of NHS hospitals were failing to meet the regulator’s staffing level standards; and reported that the RCN’s own research suggests that almost 90 per cent of nursing staff do not think staffing levels are always adequate to provide safe patient care.²

National responses

While the focus of the Francis report was on NHS England, nurse staffing concerns are not unique to England³ and there have been national policy responses in all four UK countries in the last twelve months.

The Health Minister for Scotland announced in November 2012 that the use of evidence-based nurse staffing tools, which take into account professional judgement and local care standards, would be made mandatory in all health board areas; a subsequent announcement in February 2013 reported that a community nursing tool would be introduced from May 2013.⁴ Guidance on the use of nursing and midwifery workload tools was issued to health boards in August 2013, outlining next steps to be taken by health boards. This will include requirements for board action plans, defined arrangements for reporting the outcomes of the tools, benchmarking data by boards and nationally, and a process for escalation through management structures to the Executive Nurse Director and CEO/board when the risk to nursing workforce numbers has been identified. From April 2014 onwards, all boards will be required to evidence use of all available and appropriate workload tools to inform nursing and midwifery workforce planning in local delivery plans. In August 2013 the Scottish Government also announced additional funding to recruit more NHS staff to meet the demands of an ageing population.⁵

In Wales, the Chief Nursing Officer (CNO) is leading work to introduce a suite of acuity workforce tools for organisations to locally determine the required nurse staffing levels at any given time, which is to be rolled out from April 2014. In the interim all NHS organisations are working to a set of core principles to determine nurse staffing needs in these acute areas. In July 2013 it was announced that £10 million had been allocated for additional nursing posts in the country.⁶

In Northern Ireland the Health Minister has instructed DHSSPS officials, including the CNO, to develop a new workforce plan for nurses and midwives to ensure that these key professionals are “best placed to support the delivery of safe and effective care as change takes place into the future” and has also announced reviews of the use of nursing staff deployed through banks and agencies, and a review of skill mix within nursing teams “to ensure that, as the profile and setting of care changes, all grades of staff are appropriately used and supported.”⁷

In NHS England, the Cavendish Review, published in response to the Francis report, has called for more formal training for health care assistants.⁸ This was followed by the Keogh review, a follow-up to the Francis report, which examined 14 NHS England trusts with high mortality rates and looked at nurse staffing issues.⁹

The Keogh review noted a positive correlation between inpatient to staff ratio and a high hospital standardised mortality ratio (HSMR) score in the 14 trusts. Another key finding was that actual nurse staffing levels in the trusts were below those that had been reported in national indicators. High use of temporary staff, higher use of health care assistants, low levels of nurse staffing at nights and weekends, and relatively high levels of nurse vacancies were among key staffing issues. One recommendation was that “Directors of Nursing in NHS organisations should use evidence-based tools to determine appropriate staffing levels for all clinical areas on a shift-by-shift basis. Boards should sign off and publish evidence-based staffing levels at least every six months, providing assurance about the impact on quality of care and patient experience.” The report also noted that the National Quality Board was shortly to publish a ‘how to’ guide on getting staffing right for nursing.

Most recently, the report of National Advisory Group on the Safety of Patients in England was published in August 2013. Set up as a response to the Francis report the group, led by Don Berwick, also focused on NHS staffing levels. Recommendation four in the report is that “Government, Health Education England and NHS England should assure that sufficient staff are available to meet the NHS’s needs now and in the future. Health care organisations should ensure that staff are present in appropriate numbers to provide safe care at all times and are well-supported”. The report goes on to recommend that the National Institute for Health and Care Excellence (NICE) should examine the evidence base on staffing levels, and that, “staffing levels should be consistent with the scientific evidence on safe staffing, adjusted to patient acuity and the local context”¹⁰. At the time of completing this LMR, media reports suggest that NICE has not yet been asked by government to take any such work forward.

Local solutions... a national problem?

In the last 12 months there has been unprecedented scrutiny of NHS staffing levels. In all four UK countries there has been an emerging policy focus on organisational level nurse staffing, with a move to harness the evidence base, and improve the use of staffing tools when determining local nurse staffing numbers. In NHS Scotland, Wales and Northern Ireland this appears to include some commitment to a mandatory local use of nationally approved staffing tools.. There is also an increased emphasis on the need to use temporary staff more effectively at local level, and with greater focus on the care quality impact.

Getting organisation-level staffing numbers 'right' is a critical part of the overall process of effective workforce planning but it is only one component. The other two necessary elements are, firstly, that these local staff are deployed effectively to match workload flow, through appropriate shift patterns and shift-by-shift staffing variation. Secondly that the national supply of nurses is being sustained so that current and future staffing requirements can be met.

Local application of staffing tools is irrelevant if there are insufficient nurses, with the right skills, available to be deployed locally. Effective nurse staffing requires that all these three elements are in alignment: 1) day-by-day staffing levels match workflow, 2) local staffing numbers determined by a systematic approach are responsive to local needs, and 3) the 'security' of national supply.

One key message in this year's LMR is that the national nurse supply picture continues to show problematic signs for the 'security' of national supply; this is the confidence that policymakers, planners and managers have that current and future supply will meet requirements. As such, it is a timely reminder that developing mandated tools for local application is not the only nursing workforce issue that must be addressed if patient safety is to be assured.

The key point that emerges from an assessment of current NHS nurses staffing is that there is a recent trend of reduction in NHS nurse numbers in the four UK countries, and some evidence that this decline is likely to continue without policy action.

The King's Fund, in a recent review of current and future NHS workforce, noted the likelihood of an "impending shortfall in nursing".¹¹ The review reflected an earlier report by the Centre for Workforce Intelligence (CfWI) which published projections in June 2013 that highlight a likely further decline in NHS staffing in England. Painting a stark picture, CfWI forecast future supply of registered nurses, showing a likely reduction of between 0.6 and 11 per cent (63,800 nurses) between 2013 and 2016. Forecasts of future demand varied between an increase of 23 per cent and a reduction of 7 per cent by 2016. Overall, the baseline projections for supply and demand show a shortfall of nurses by 2016.¹² These findings are similar to the projections undertaken for the LMR in 2011, which highlighted a likely significant decline in NHS nurse supply in England over the next 10 years.¹³

Both CfWI and the 2011 LMR highlighted that the ageing nursing workforce would be a major contributor to likely reductions in supply, as more current NHS nurses reach

retirement age. Both reports also noted that some of the main policy options for responding to this shortfall were: to increase the numbers of new nurses being trained in the UK; to improve retention of current NHS nurses; or to restart a significant level of active international recruitment.

While there have been no similar published analyses in other UK countries, the planned review of nurse staffing in NHS Northern Ireland, and the announcement of a slight increase in training commissions in NHS Scotland suggest that policymakers are becoming more focused, in the short term at least, on trying to maintain future supply.¹⁴

The other main change in NHS workforce planning over the last year has been the formal establishment of the new, post-reform planning system in England. The new system, delayed in implementation, has begun functioning with the publication of the mandate for Health Education England (HEE) in May 2013.¹⁵ This sets out a blueprint for NHS staff training, with a long list of objectives to be reached by 2015, and is predicated on effective local planning and commissioning, through the recently established Local Education and Training Boards (LETBs). The mandate focuses on recruitment in to all new NHS-funded training posts, and delivery of additional trained health visitors to increase the workforce by 4,200 full-time equivalents by April 2015. No other nurse staffing targets are mentioned.

The HEE mandate shows a strong imprint of the post-Francis report concerns around values and compassion, plus other longer-term Government commitments to increase numbers of health visitors, and address dementia/mental health issues. The National Audit Office in a recent overview of the implementation of the wider NHS reforms in England noted that “the new organisations were ready to start functioning on 1 April 2013, although not all were operating as intended. Some parts of the system were less ready than others, and much remains to be done to complete the transition.”¹⁶

It's about NHS funding

The growing policy concern about NHS nurse staffing levels is set against a backdrop of the post-recession impact on NHS funding and the NHS workforce. One result of NHS funding constraint has been an ongoing decline in NHS nurse staffing numbers across the four UK countries, in part the result of recruitment freezes, in part redundancies. Other impacts of NHS cost containment in recent years have been a reduction in the number of pre-registration nurse education places being commissioned, reduced investment in upskill of current staff, and NHS staff pay freezes. In combination, these actions are reducing the numbers of new nurses entering the UK labour market, and the job opportunities and career mobility for current nurses.

NHS cost containment and funding constraints are predicted to continue. According to recent King's Fund estimates, NHS funding levels in England up to 2014/15 in real terms will “at best” be at a standstill, Northern Ireland funding will reduce by 2.2 per cent, Scottish NHS funding will reduce by 4.2 per cent, and in Wales 10 per cent is projected.¹⁷

Two initial responses to tightening NHS funding have been national level pay freezes, and local level staffing cuts or keeping posts deliberately unfilled. Audit Scotland has noted that

cost pressures on NHS boards means that nursing and midwifery numbers are “forecast to reduce by four per cent across 2011-15.”¹⁸ In England, the National Audit Office, noted that much of the NHS savings achieved to date have been as a result of the NHS staff pay freeze and has stressed that “....the NHS has started by making the easiest savings first...There is consensus that service transformation, such as expanding community-based care, is fundamental to making future savings but only limited action has been taken so far.”¹⁹ Similarly, the Nuffield Trust has noted that NHS spending on staffing has reduced since 2010/11, with a reduction of £1.5 billion in 2011/12, as a result of NHS pay freezes and a reduction in staffing levels.²⁰

On the basis of currently available data and projections, there will be no alleviation in the pressure on NHS funding, and therefore on NHS staffing levels, in the foreseeable future. For example, the Nuffield Trust has calculated that after 2014/15, to avoid cuts to the service or a fall in the quality of care, the NHS in England must either achieve unprecedented sustained increases in productivity, or funding will need to increase in real terms. Pressure on the NHS is projected to grow at around four per cent a year up to 2021/22, arising from growing demand for health care to meet the needs of an ageing population, a population which is growing in size and experiencing more chronic disease. If NHS funding in real terms is held flat beyond the current spending review period, the NHS in England could experience a funding gap of between £44 and 54 billion in 2021/22. This is unless offsetting productivity gains can be delivered.²¹

The NHS is facing unprecedented pressure on its funding levels, and has already focused on staffing levels as a source of cost savings. But it also has to take account of the safe staffing issues that have become so prominent because of the management, staff planning and governance inadequacies highlighted in the Francis report and the Keogh report. These countervailing pressures on NHS nurses, of NHS cost containment and the need for a workforce system that can ensure both security of national supply and local sufficiency, have been exposed by the 2013/14 annual review of Monitor, the NHS foundation trusts’ watchdog. The review demonstrates that, at aggregate national level, foundation trusts’ business plans suggest that they intend to recruit 4,133 nurses in 2013/14, but that in subsequent years there will be a projected significant decline in staffing, a result of the need to meet funding constraints.

Each foundation trust covered by the Monitor report would no doubt argue that it is making rational business decisions based on its business plan. However, when the projections from all these business plans are aggregated to national level, the result is this ‘stop- go’ effect (or, more accurately ‘go-stop’), with significant year-by-year swings in projected nurse staffing requirements, driven by short-term local funding projections.²² This presents real difficulties in terms of sustaining the security of the national supply of nurses and ensuring that there is some degree of career predictability so that these nurses can be retained and receive additional training as required.

This volatility would be the reality of any workforce planning system that is ‘local employer led’ – the national impact of aggregate short-term local decisions can be magnified and suggest a collective mood swing rather than an evidence-based approach. HEE and LETBs in

England will have to play a significant role in both quality assuring trust level workforce planning approaches, and trying to dampen down the national effect of such swings.

The NHS is labour intensive, and nursing is numerically one of the largest elements in the workforce. Any assessment of the NHS nursing workforce must start from a position of acknowledging that NHS funding levels are a major determinant both of the current profile, and likely future shape of the profession. The NHS is the sole provider of support for home-based education of 'new' nurses to enter the UK nursing labour market, and is the main source of employment for qualified nurses. In addition, Government policy plays a major role in determining pay rates for nursing staff, and in facilitating, or blocking, entry to the UK of non-EU workers. In short, Government, through funding levels and other policy decisions, has the ability, if it chooses, to ensure that the supply of nursing staff is 'secure', as in sufficient to meet need.

The reality of an actual decline in NHS nurse staffing numbers in recent years, which we discuss further in this year's LMR, is not a random occurrence, or driven by external factors. It is the result of policy decisions. The ageing of the nursing workforce, which is also discussed in this report, is likely to accelerate this trend of decline unless policymakers accept that reduced intakes to pre-registration nurse education will make a significant contribution to a continued drop in overall supply of nurses. And any significant reduction in nurse supply would undermine locally focused efforts to develop more responsive approaches to determining staffing levels.

This year's LMR continues with the following three sections:

Section 2 presents an analysis of the UK nursing workforce

Section 3 gives attention to the UK nurse education pipeline

Section 4 presents a specific assessment of the key challenges facing NHS community nursing

2. The UK Nursing Workforce

Table 1: Whole-time equivalent and percentage change in the NHS qualified nursing and midwifery workforce, 2002 and 2010 - 2012, four UK countries (September)

	2002	2010	2011	2012	% change 2002 - 2012	% change 2010 - 12
England	268,214	309,139	306,436	305,060	13.7	-1.3
Scotland	37,260	42,513	41,495	41,159	10.5	-3.2
Wales	18,766	21,823	21,733	21,779	16.1	-0.2
Northern Ireland	11,558	13,899	13,649	13,823	19.6	-0.5

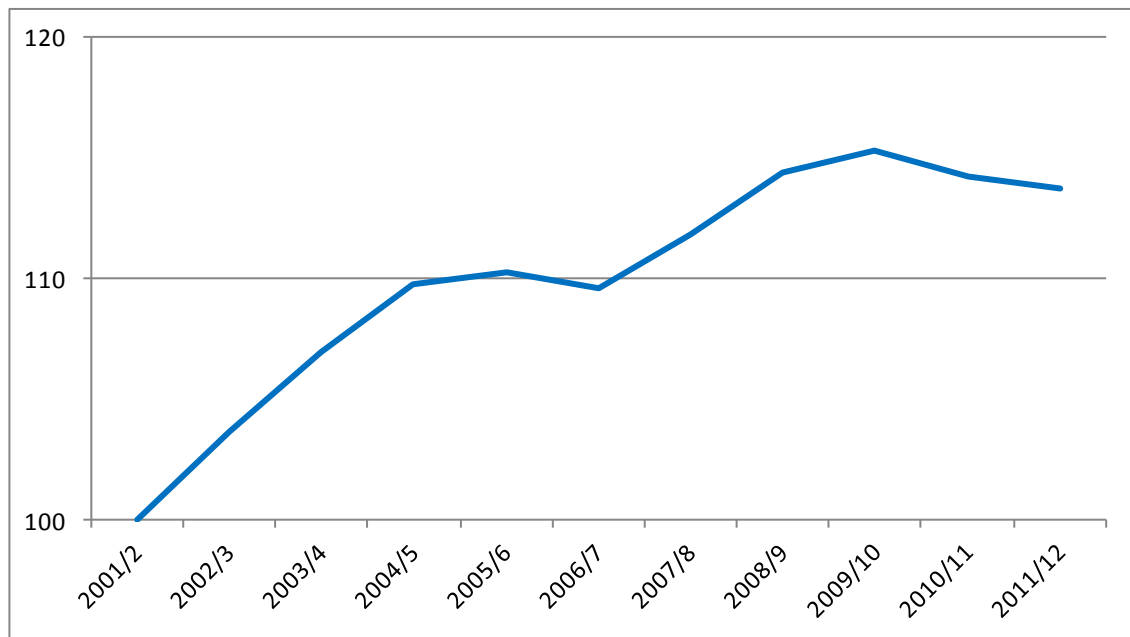
Sources: England: non-medical workforce census, excludes bank and agency. The NHS Information Centre. Northern Ireland – DHSSPSNI; data is for March; Scotland data - ISD Workforce Statistics; Wales – StatsWales. Note: per cent figures are rounded. NOTE: Scotland data for 2010-12 is not directly comparable with that from 2002 as data collection was re-calibrated using Agenda for Change bands after 2006. Data for 2012 is for bands 5-9.

NHS nursing workforce numbers: long-term growth, recent decline

NHS data on the nursing workforce cannot easily be aggregated to a UK level because of differences in definitions and collection methods in the four UK countries, so most trend analysis is best conducted at the level of country within the UK. Table 1 uses national NHS workforce data from the four UK countries to assess overall growth in the last ten years, and the trend across the period 2010-12. It shows that significant but variable levels of overall nurse staffing growth of 10 per cent to 19 per cent had been achieved in the four UK countries over the period 2002-2012. However the pattern in 2010-12 is one of nurse staffing decline. The staffing growth that was achieved occurred in the earlier part of the 10 year period; in all four UK countries, this growth has tailed off as NHS funding constraints have begun to have an impact.

The data in the table must be interpreted with caution because staffing change at two points in time may give little sense of variation in change across the period under examination, and can also be skewed by the choice of start and finish dates. This final point is illustrated in more detail below.

Figure 1: NHS England: qualified nursing and midwifery staff, full-time equivalent (FTE), 2001/2 – 2011/12 (2001/2=100)

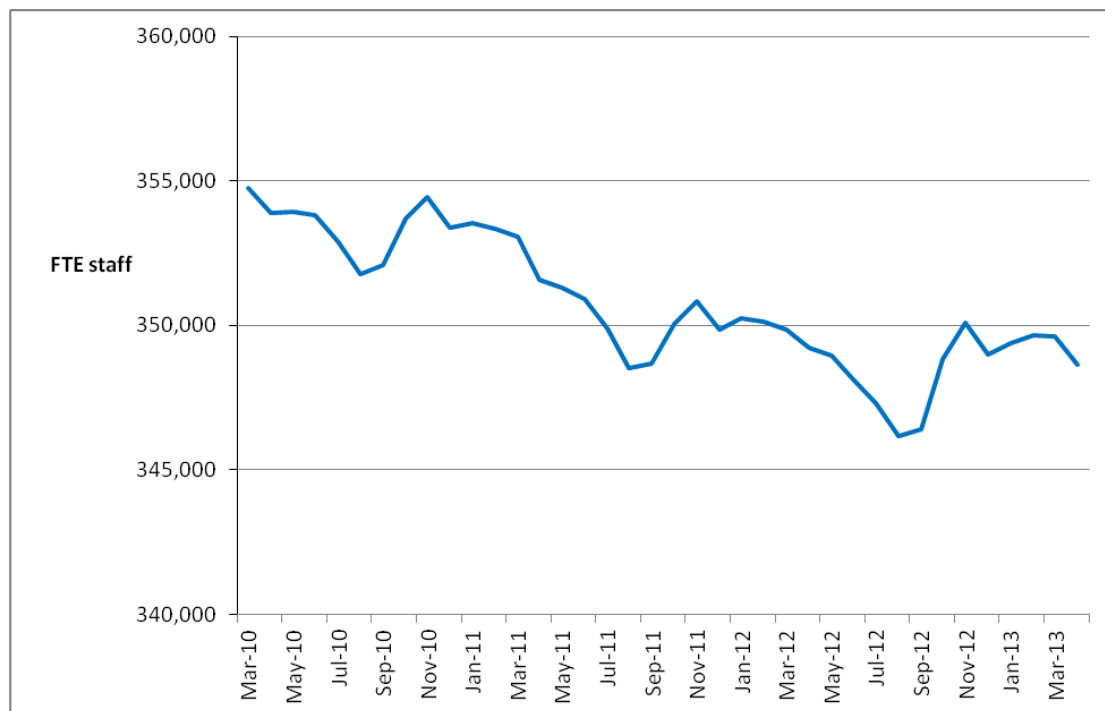


Source: Health and Social Care Information Centre

NHS England nursing workforce: the end of growth...the beginning of decline?

Figure 1 shows the trend in NHS qualified nursing staff in England across the period 2001/2 to 2011/12. It highlights that most of the growth was achieved in the earlier part of the period, followed by a plateau in 2004/5 to 2006/7, at a time of previous NHS funding concerns. In recent years, growth has tailed off with a slight year-on-year decline in the NHS qualified nursing workforce since 2009/10.

Figure 2: NHS England monthly staffing, qualified nursing, midwifery and health visiting staff (FTE), March 2010 – April 2013

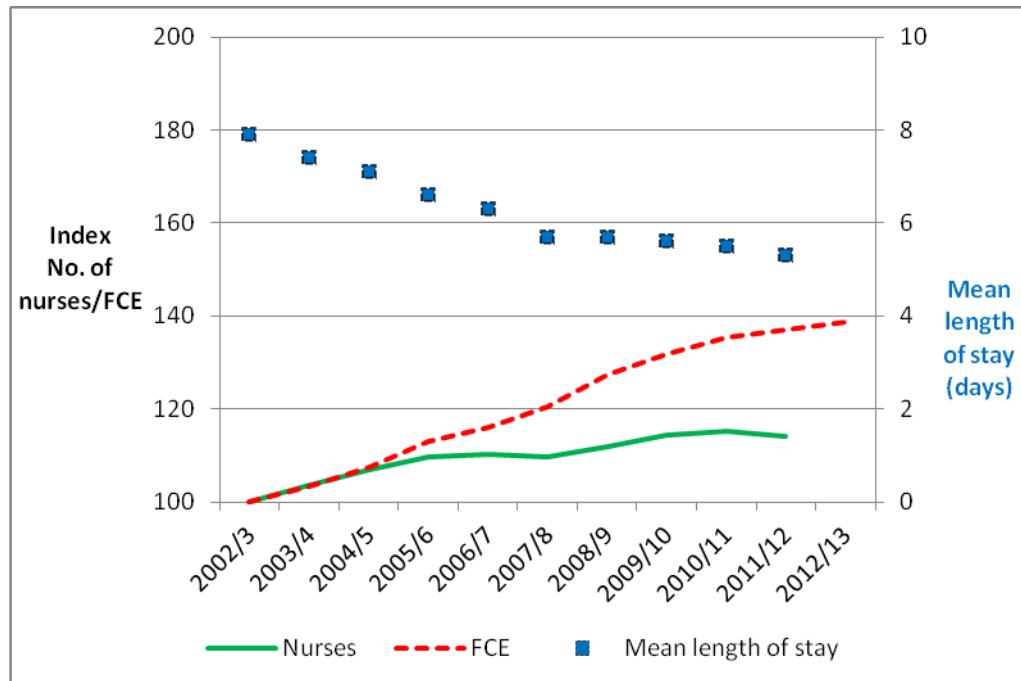


Source: Health and Social Care Information Centre

Recent decline in NHS nursing numbers

In more recent years, the NHS in England and Scotland has begun to publish staffing data more rapidly and frequently. This allows a more detailed picture of staffing change to be assessed. Figure 2 shows the trend in NHS qualified nursing workforce in England on a monthly basis since March 2010. It is clear that the staffing decline over the period has not been steady, but rather that there has been a variable pattern. In most years, there appears to have been a slight growth in the September-December period, and a more rapid decline in the March-June period.

Figure 3: NHS England: qualified nursing and midwifery staff (2002=100); nurses and finished consultant episodes (FCE) 2002/3 – 2012/13 (2002=100); and mean length of stay in hospital (LOS)



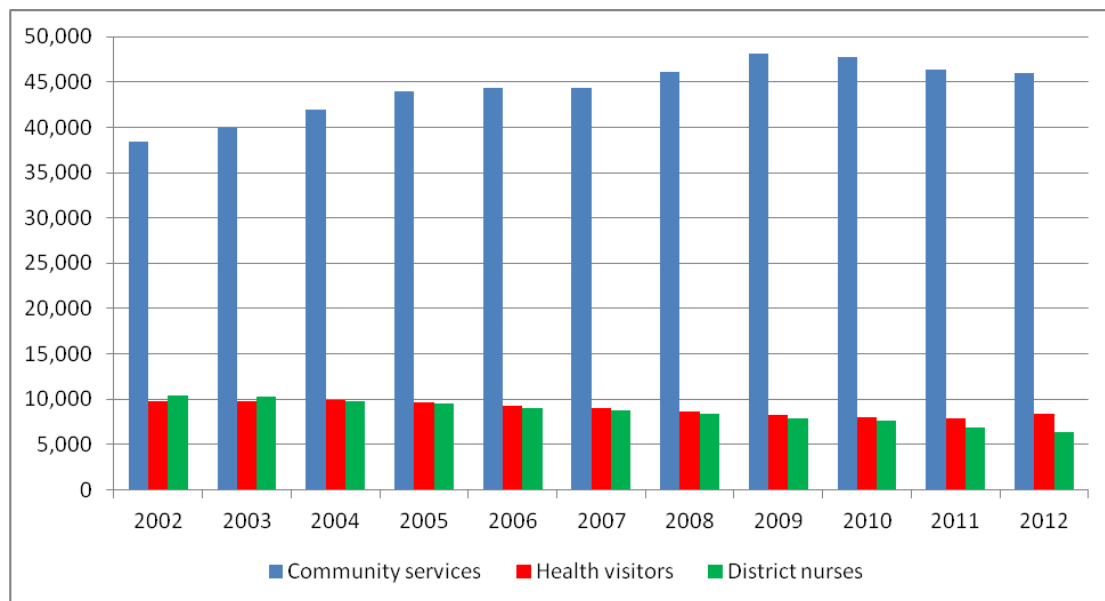
Source: NHS HCHS; Time Series Data from 2000/01 to 2010/11 from publication tables, Health and Social Care Information Centre

NHS activity growth outstrips nursing numbers

Figure 3 shows that in England, NHS nurse staffing grew by 11.2 per cent between 2002/3 and 2009/10 then tailed off, dropping by 1.3 per cent between 2009/11 and 2012/13. However, NHS activity, as measured by FCEs continued to grow by 36 per cent across the same period.

Mean length of stay of patients has also continued to drop across the period. While this is a crude indicator, at the highest level of assessment this means that more patients are being treated, more quickly, in acute services. With patients on the wards for a shorter period of time, the average level of patient acuity is also higher, requiring more intense care. Overall, this suggests that workload of nurses in acute care will have continued to grow even as staffing numbers have tailed off. This emphasises the need for a continuing local focus on accurate assessment of patient acuity and workload when determining staffing levels.

Figure 4: Qualified nursing workforce, NHS England: community services; health visitors (HV); district nurses (DN), 2002 to 2012 (full-time equivalent)



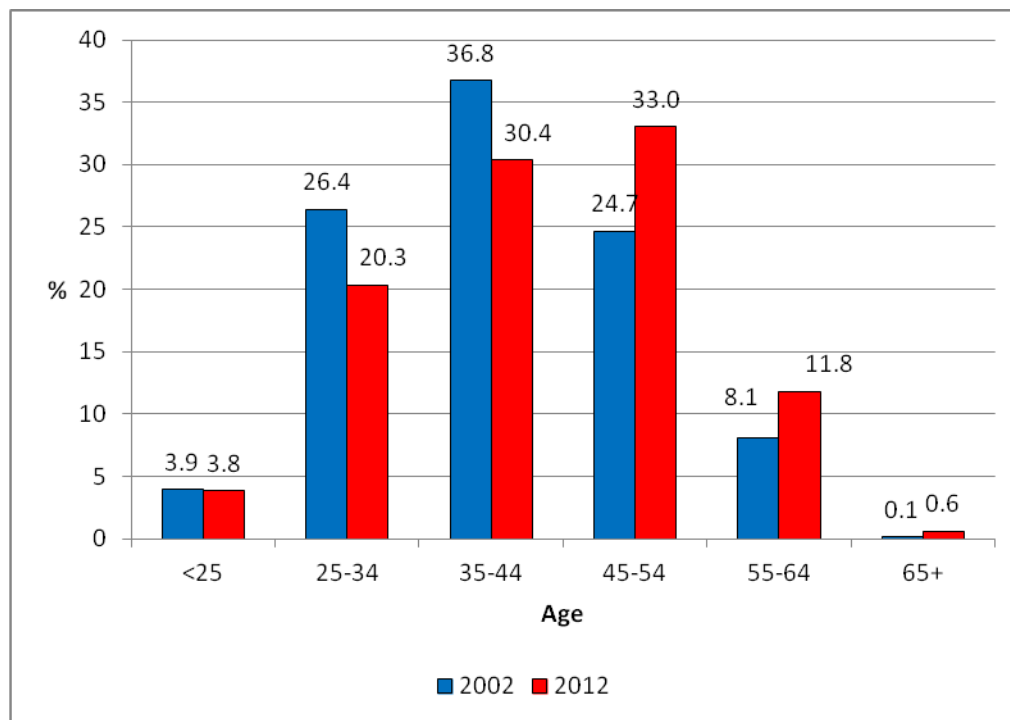
Source: NHS non medical workforce census, Table 2b, table 3b. NHS Information Centre

NHS community services are the policy priority, but there is no recent growth in the community nursing workforce

Community and primary care are regarded as the NHS policy priority areas, with governments in all four UK countries expressing policy intent to shift care from acute/hospital care to primary/community care. Data for NHS England, in figure 4 above shows there is no sign that there has been any commensurate expansion in the community nursing workforce in recent years to match this intent.

The overall size of the community nursing workforce grew over the period from 2002 up to 2009, when there were 48,106 WTE, but since then there has been a decline in numbers, with 46,035 reported in 2012. Within this overall headline figure, there has been continuous decline in the number of district nurses, down from 10,446 in 2002, to 6,381 in 2012. The health visitor (HV) workforce, which has been the focus of preferential policy attention in recent years, declined until 2011, and has then grown slightly, but has remained below the 2002 level.²³ In Wales, DN numbers have also dropped, from 903 in 2002 to 780 in 2012, while HV numbers have grown. The implications of this stalled growth in the NHS England community nursing workforce are examined in greater detail in Section 4.

Figure 5: NHS England: age profile, qualified nursing staff headcount, September 2002 and 2012



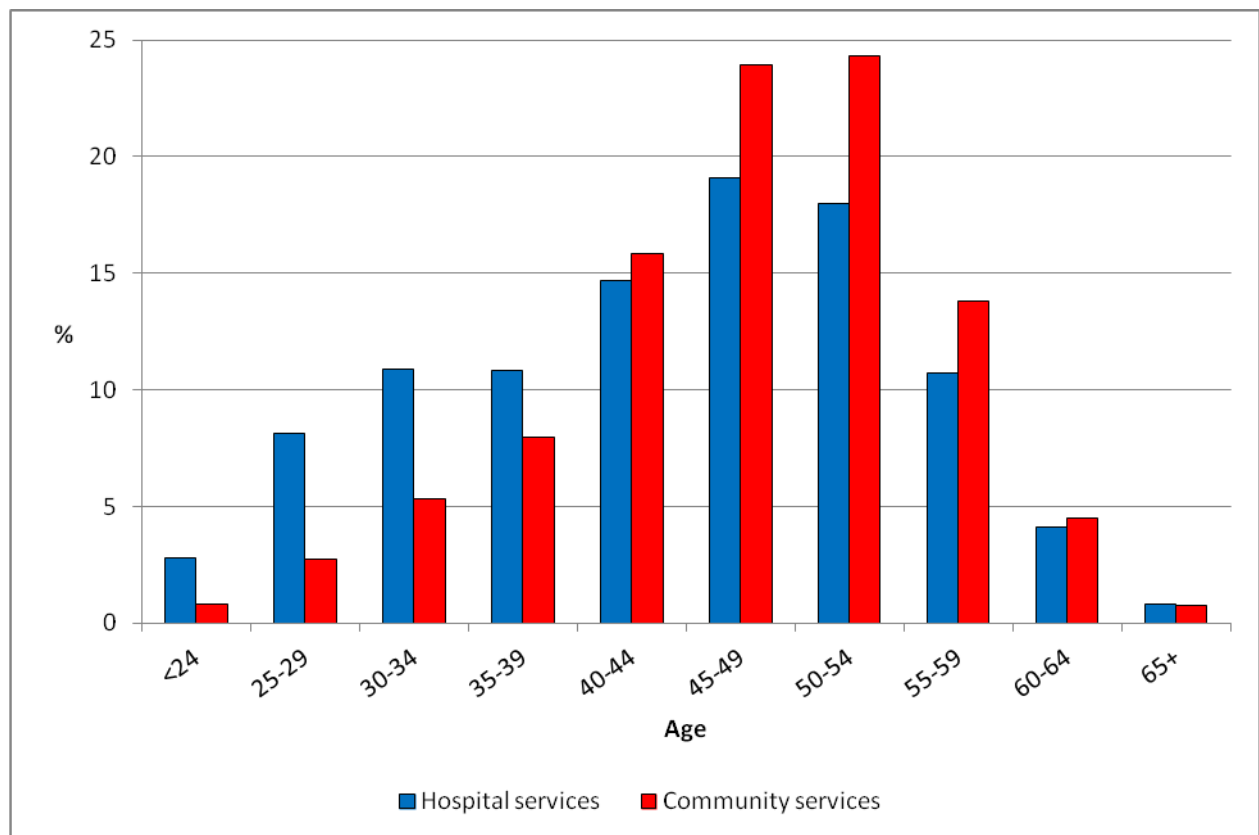
Source: Department of Health, 2002 and 2012, non-medical workforce census.

Note: Excludes staff in 'unknown' categories.

The NHS nursing workforce is ageing

The NHS qualified nursing workforce is ageing. Figure 5 shows the age profile of the nursing workforce in England in 2002 and 2012. The shift in age profile is clear. In 2012, almost 50 per cent of the workforce was aged 45 or older, compared to 33 per cent in 2002. This ageing is likely to continue, as a result of reduced intakes of younger nurses from training, and more nurses staying on in work because of the labour market impact of the recession and changes in NHS retirements. There will be a growing replacement challenge as the large number of nurses in the 45 plus age reach retirement age. The NHS Staff Council has recently published a review of research on the impact of ageing in the NHS workforce, with ageing of the nursing workforce identified as a major challenge.²⁴

Figure 6: NHS Scotland: nursing and midwifery staff age profile, hospital and community services, 2013 (headcount)



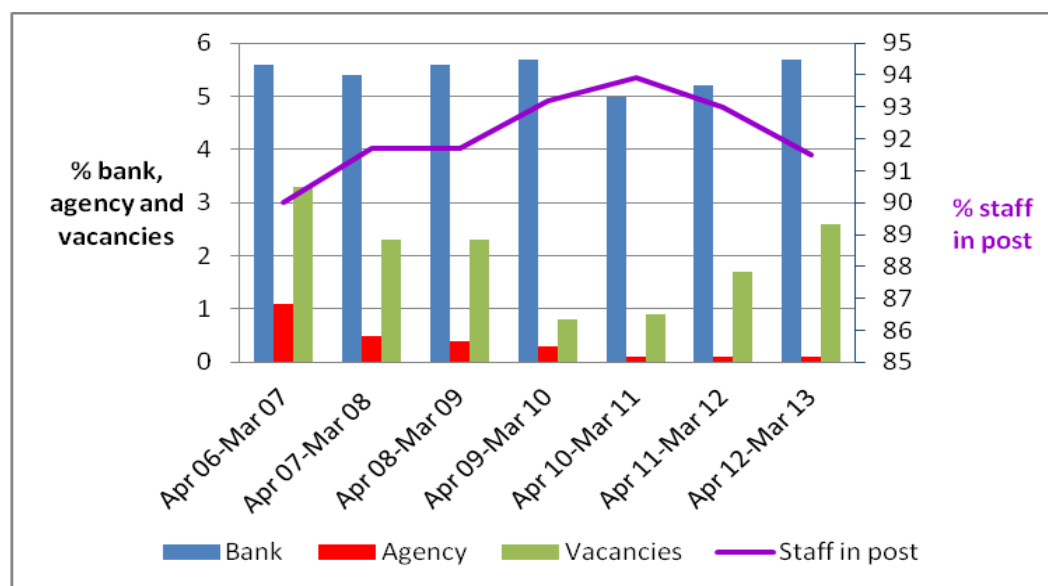
Source: Scottish Workforce Information Standard System (SWISS)

Community nursing has an older age profile

The age profile of the NHS nursing workforce differs in different areas of practice. NHS community services employ an older nursing workforce than does the hospital sector. Figure 6 contrasts the age profile for nursing and midwifery staff in community and hospital services in NHS Scotland.¹ The community nursing profile is markedly older. Almost 50 per cent of NHS community nurses in NHS Scotland are aged 50 or older, with a similar pattern in the other UK countries. This means that the replacement challenge of dealing with a high and growing incidence of retirements will be most pronounced in the community sector – the very sector earmarked by policymakers as the priority focus for NHS service changes. NHS England is reportedly offering ‘sweeteners’ to health visitors to discourage them from retiring²⁵.

¹ The data presented on the community nursing workforce is the best available. However, it should be noted that a Government working group has been set up to improve the quality of data.

Figure 7: NHS Scotland: nursing and midwifery bank and agency nurses percentage capacity, 2006-2013



Source: Scottish Workforce Information Standard System (SWISS)

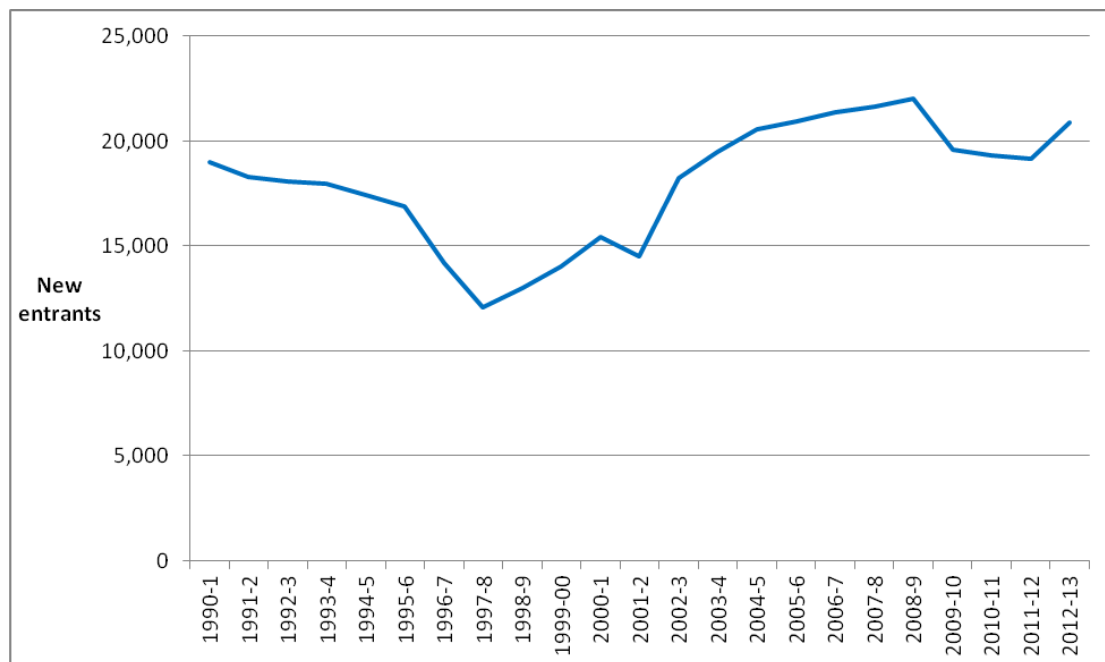
The invisible contribution of temporary nursing

One important aspect of NHS qualified nurse staffing is the contribution of temporary staff, employed as agency nurses or bank nurses to provide cover for vacancies and absent permanent staff. There has been a continuing debate about the cost and quality aspects of the deployment of agency nurses, and level of agency use has been used as an indicator of staff shortages. The Keogh report, discussed in Section 1, highlighted the relatively high use of temporary nursing staff in the 14 England NHS trusts with a high Hospital Standardised Mortality Ratio (HSMR) score.

Changes in data acquisition and publication protocols mean that the contribution of these staff has become almost invisible in NHS England, Northern Ireland and Wales, where regular publication of agency and bank numbers have been discontinued. This means that trends in their use cannot be tracked independently with any certainty; just at a time when the Department of Health has announced the need for a significant reduction in spend on NHS temporary staffing.²⁶

Data from NHS Scotland shown in figure 7 above suggest that the level of bank nurse use has stayed at a similar proportion to permanent staff across the period since 2006. The proportion of bank staff ranged from 5.6 per cent in 2006/07, down to 5 per cent in 2010/11 and up 5.75 per cent in 2012/2013, while the proportion of permanent staff ranged between 90 per cent and 93.9 per cent over the same period. The use of agency nurses has reduced (from 1.1 per cent in 2006/2007 to 0.1 per cent between 2010/11 and 2012/13), but the level of vacancies has grown markedly in the period since April 2010 (from 0.9 per cent in 2010/11 to 2.6 per cent in 2012/13).

Figure 8: Number of new entrants to the UK nursing register from UK sources, 1990/1 to 2012/13.



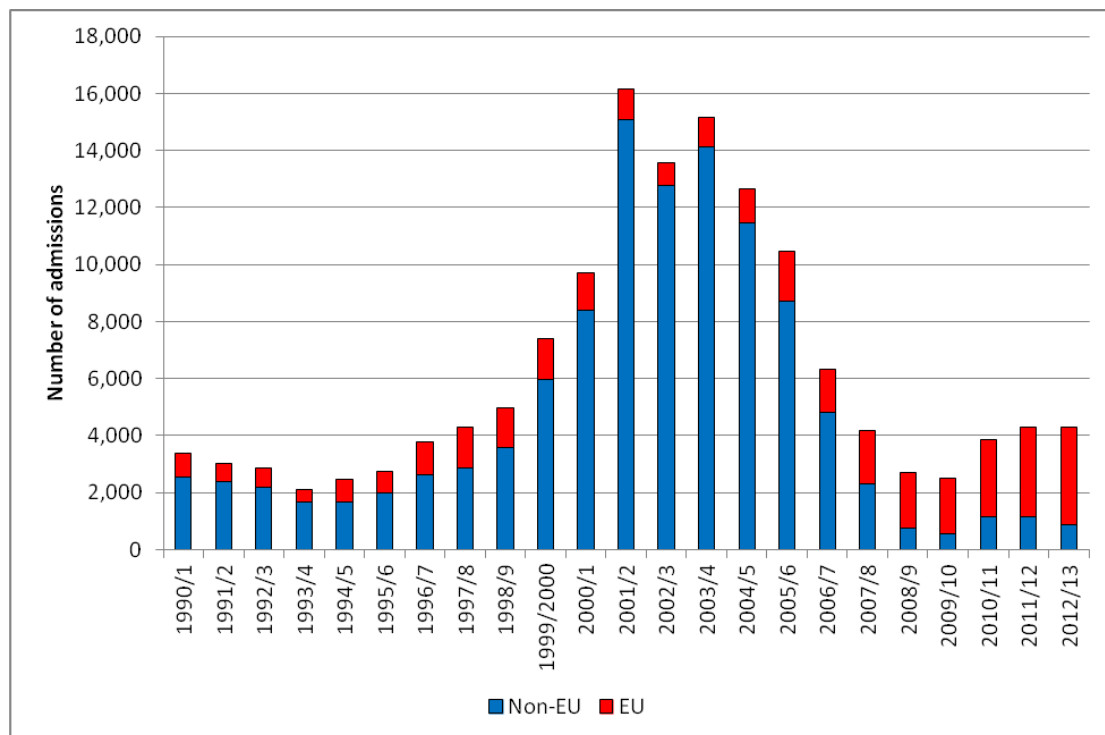
Source: Nursing and Midwifery Council; data publication was discontinued in 2009; data for more recent years obtained under the Freedom of Information Act

Bust...boom...bust? Trends in numbers of 'new' nurses entering the UK register

Data from the NMC and its precursor (the United Kingdom Central Council for Nursing, Midwifery and Health Visiting) can be used to provide a picture of the varying levels of 'new' nurses entering the labour market from UK training. The NMC data shows the annual number of new registrants from UK education. As a nurse cannot practise in the UK without being registered, the NMC registrant data is a source of 'whole population' information.

Figure 8 shows the decline in the annual number of new registrants which occurred in the period up to 1997/8 which reflected reduced intakes to pre-registration education earlier in that decade. There was then a period of growth up to 2009/10, reflecting increased intakes to pre-registration training, driven by increases in NHS funding. There is a time lag between nurse education places being commissioned and student nurses subsequently completing their pre-registration education and becoming eligible to be registered. The more recent picture suggests a decline in 2010 to 2012, in part at least a reflection on earlier reductions in the number of student nurses.

Figure 9: Admissions to the UK nursing register from EU countries and non-EU countries, 1990/1 – 2012/3.



Source: Nursing and Midwifery Council

Growth and decline in international inflow; EU nurses now more prominent

The UK has been a traditional 'destination country' for English-speaking nurses from a range of Commonwealth countries, Ireland and the Philippines. More recently, a broader range of EU countries has become more significant as source countries. Figure 9 shows the pattern of annual registration of nurses from EU countries and non-EU countries since 1990. This NMC data shows that registration has occurred; it does not necessarily mean that every nurse that was registered actually moved to and worked in the UK, but it does provide a good source of overall trends.

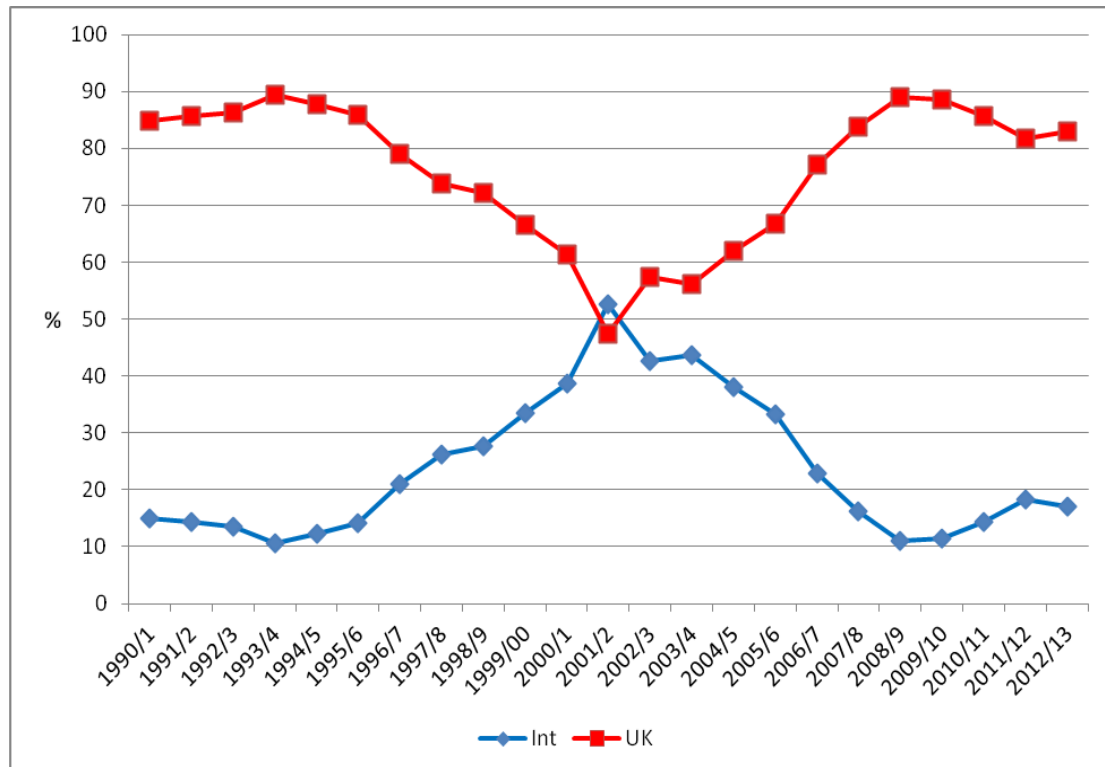
Figure 9 shows the period of rapid growth in inflow of international nurses to the UK register from 1998 to 2004. This reflected a time of policy-led, active international recruitment, when the NHS, notably England, was recruiting nurses from the Philippines, South Africa, India and other countries to meet NHS staffing growth targets.

There followed an equally rapid decline in international inflow over the period 2005 to 2010. This was a result of a decrease in demand for international nurses, tightened immigration policies that applied to non-EU nurses, and more costly application requirements being implemented by the NMC for non-EU international nurses.

EU-trained nurses have the right to practise in the UK and cannot be subject to immigration restrictions in the same way as non-EU nurses. It is notable that EU countries have progressively become a more significant source of nurses, compared with non-EU countries.

In 2012/13, EU nurses accounted for 79.8 per cent of inflow, many coming from Portugal, Spain and Romania.

Figure 10: International and UK sources as percentage of total new admissions to the UK nursing register, 1990/1 – 2012/3 (Initial Registrations)

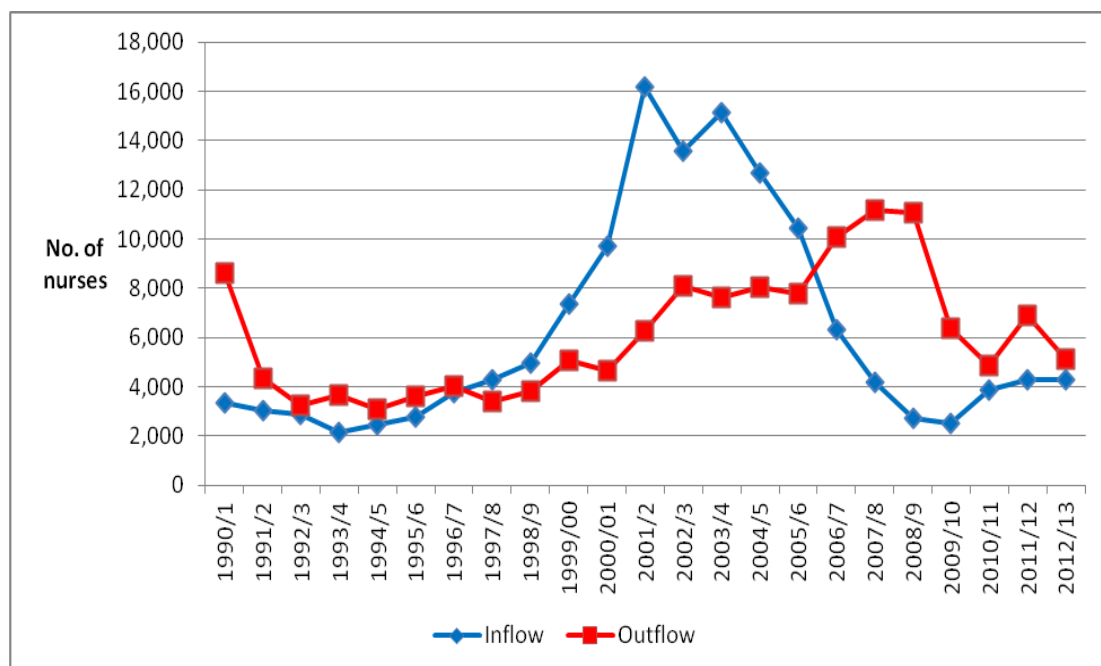


Source: UKCC/ Nursing and Midwifery Council data

Growth and decline in reliance on international nurses

The relative importance of international and domestic sources of 'new' nurses for the UK is shown in figure 10. This shows the percentage of nurses entering the UK register annually, from UK and international sources. Reliance on international nurses peaked in 2001/2 when more than half of new nurses on the UK register came from international sources. Reliance on international sources declined rapidly until 2008/9 and remains below one in five new entrants - most from the EU.

Figure 11: Inflow and outflow of nurses from the UK, 1990/1 – 2012/13.



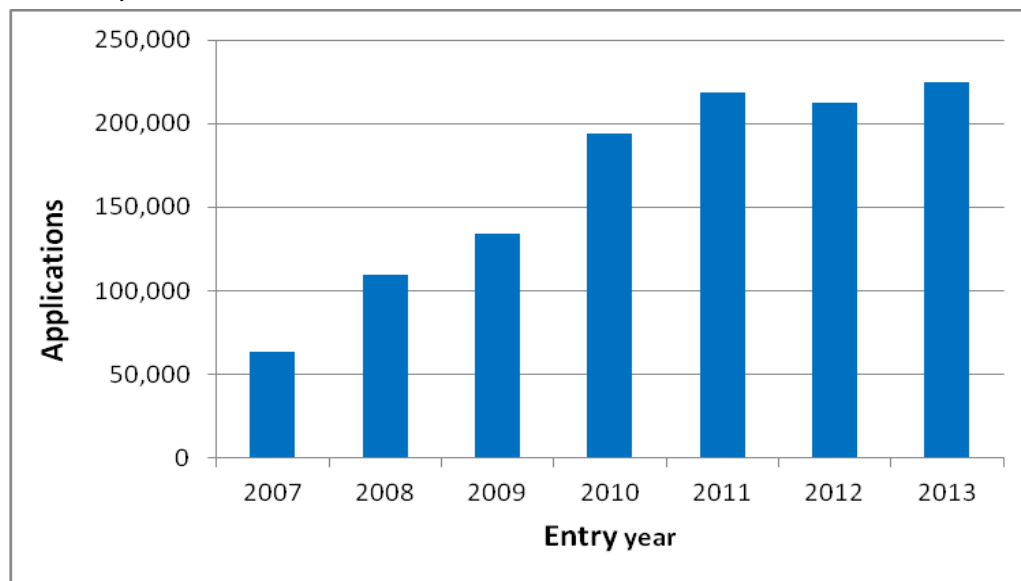
Source: Nursing and Midwifery Council

The UK has moved from being a net importer to an exporter of nurses

Nurses leave the UK mainly to other English speaking developed countries - Australia, Canada, USA, New Zealand and Ireland. The NMC records verifications issued to other countries, which is one measure of outflow; it indicates an intent to move rather than an actual move but provides one source of information on trends. NMC verification data (outflow) and registration data (inflow) is shown in figure 11. While inflow peaked in 2002, outflow grew in the period up to 2008/9. Both flows have been at a lower level in recent years.

3. The Nurse Education Pipeline

Figure 12: Applications for entry to nursing courses at higher education institutions (HEIs) in the UK, 2007-13



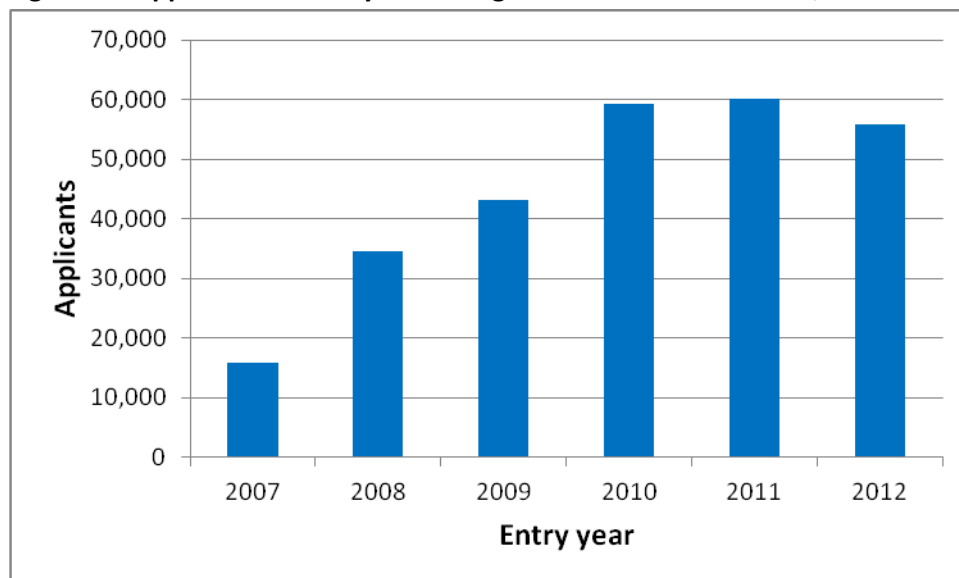
Source: UCAS media releases

Applications for entry to nursing education courses remain buoyant

UK-wide statistics on the number of applications made by those seeking to enter a nursing course at a higher education institution (HEI) in 2013 shows an increase of almost 12,000 (5.6 per cent) compared with 2012 when applications fell by about 6,000 (2.8 per cent). The number of applications is a broad based indicator of interest in nursing. Individual applicants may make up to five applications to different courses or institutions.

Although the long-term trend shows a slowing in the rate of growth, the number of applications to nursing courses (224,562 in 2013) is still increasing at almost twice the rate for all subjects (3.1 per cent) and substantially faster than medicine and dentistry (1.2 per cent). The evidence from the applications statistics suggests that, despite a slight dip in 2012, student demand for education in nursing remains strong.

Figure 13: Applicants for entry to nursing courses at HEIs in the UK, 2007-12



Source: UCAS annual datasets (subject dataset v2.0, JACS3 subject line B7 Nursing)

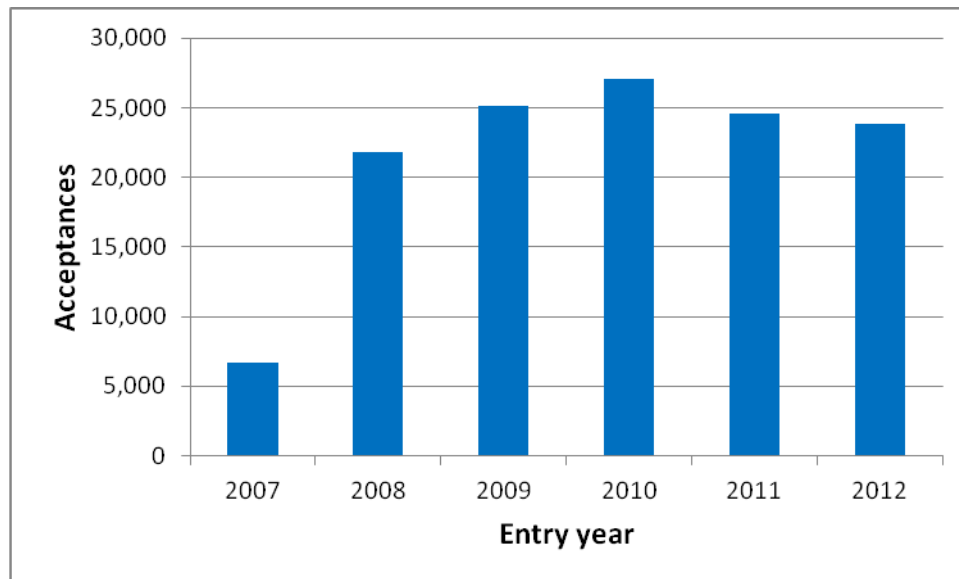
Applicant numbers dropped in 2012

Although more up to date, the applications statistics presented in figure 12 give a slightly misleading picture of volume of interest, since each individual can make up to five choices. Figure 13 shows the trend in the actual numbers of applicants. These figures include EU (1,547) and non-EU (361) domiciled applicants – who together make up around 3.4 per cent of the total, as well as those from the UK.

The number of UK domiciled applicants stood at just under 54,000 in 2012, compared with 58,000 in 2011. Having increased rapidly for several years, growth slowed to less than two per cent in 2011 and 2012 saw the first reduction: by a little over 7 per cent (4,300). Applicant figures for 2013 are not yet available but are likely to have increased in line with applications.

More detailed analysis of UCAS applicant numbers from the four UK countries²⁷ shows that applicant numbers in England were 44,667 in 2012, having fallen from their peak in 2011 of 48,328, a decline of just under eight per cent. Applicant numbers have also fallen in Scotland, declining in 2011 by two per cent from a peak of 5,486 in 2010 and by a further nine per cent to 4,838 in 2012. In contrast, applicant numbers have risen continually in Wales, peaking at 2,940 in 2011 and remaining at this level, while in Northern Ireland applicant numbers have more than doubled, from 712 in 2007 to over 1,500 in 2012.

Figure 14: Acceptances for entry to nursing courses at HEIs in the UK, 2007-12

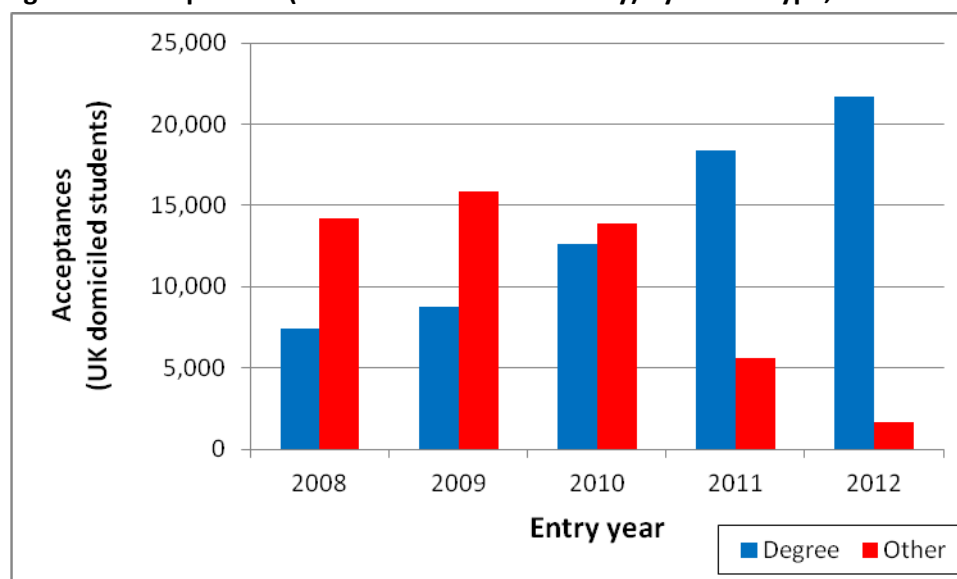


Source: UCAS annual datasets (subject dataset v2.0, JACS3 subject line B7 Nursing)

Acceptances on to courses declined in 2011 and 2012

Of greater short-term importance from a labour supply point of view is the number of applicants accepted on to courses. While the number of applications and applicants shows (with the exception of 2012) a rising trend, the number of applicants accepted on to courses has fallen for the past two years, dropping by just over nine per cent from 2010 to 2011 and by three per cent between 2011 and 2012. The decline is such that the number of UK domiciled students (EU and non-EU students account for about 500, or two per cent of all acceptances) accepted on to courses in 2012 was five per cent fewer than the number accepted in 2009. This means that fewer newly registered nurses will be available in 2014/15 and 2015/16.

Figure 15: Acceptances (UK domiciled students only) by course type, 2008-12



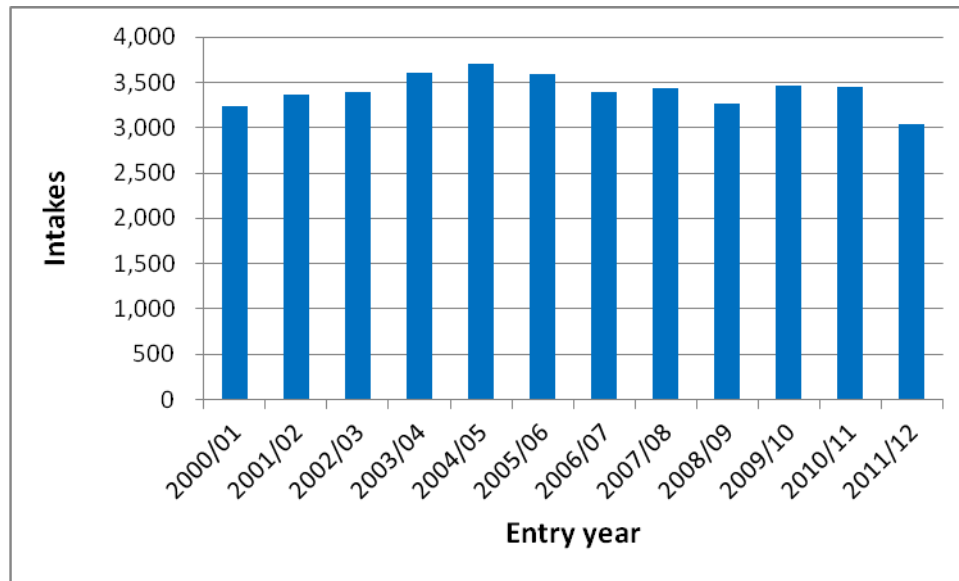
Source: UCAS annual datasets (subject dataset v2.0, JACS3 subject line B7 Nursing)

Rise in degree course intakes outpaced by fall in diploma courses

The overall figures on acceptances disguise the switch from diploma to degree courses. Figure 15 shows the contrasting trends. Although the overall number of acceptances fell between 2011 and 2012, acceptances on degree courses have continued to rise year-on-year, reaching 21,718 in 2012 (an 18 per cent increase over 2011). The overall decline is accounted for by a 71 per cent drop in acceptances to diploma courses. Having been the majority in 2010, diploma courses account for just seven percent (1,621) of acceptances in 2012. While acceptances onto degree courses have continued to rise, the increase does not equate the loss of diploma course places.

More detailed analysis of the data shows that England has had a continuous and rapid rise from just under 5,000 acceptances in 2007 to 17,421 in 2012, an average increase of around 2,500 extra students per year. The figures for Wales show a more modest increase, from 834 in 2007 to 1,174 in 2012, while in Northern Ireland acceptances only increased from 400 to 519, with falling numbers in years 2009 and 2010. The trend in Scotland is less distinct as acceptances onto courses in Scotland were not recorded by UCAS prior to 2010. Since then acceptances have increased from 2,238 to 2,731 in 2011, but then fell back by 4.7 per cent to 2,604 in 2012.

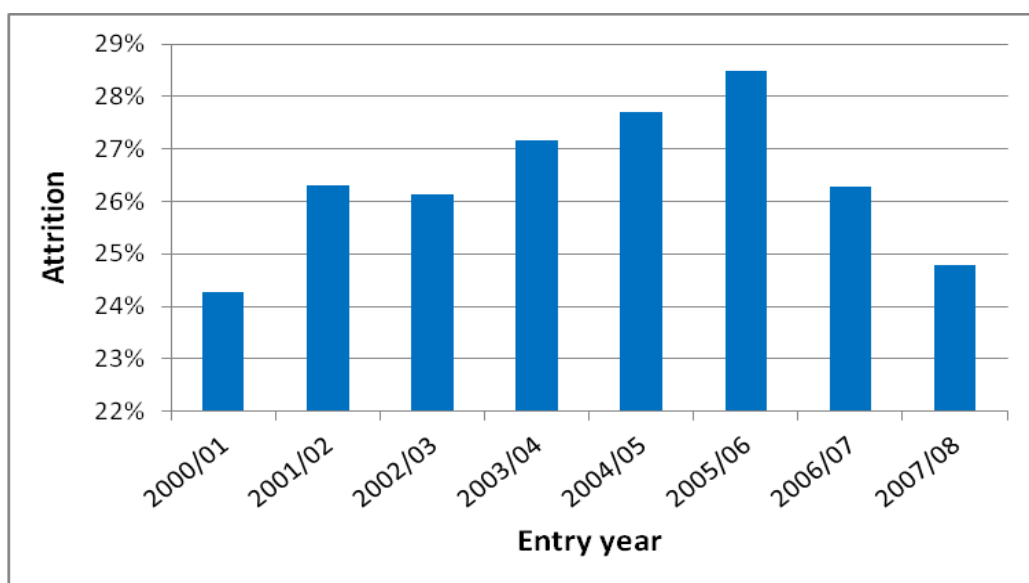
Figure 16: Scotland: nursing and midwifery student intakes, 2000/01 to 2011/12



Source: IDS Scotland, NHSScotland Workforce

Figure 16 provides a more consistent longer-term view of intakes to nursing and midwifery education courses in Scotland. This shows that the student intake has decreased from a peak of just below 3,700 in 2004/05 to 3,037 in 2011/12, its lowest level this century.

Figure 17: Scotland: attrition rates for students on diploma courses, 2000/01 to 2007/08



Source: IDS Scotland, NHS Scotland Workforce

The dropout rate from nursing courses may be falling, but evidence is limited

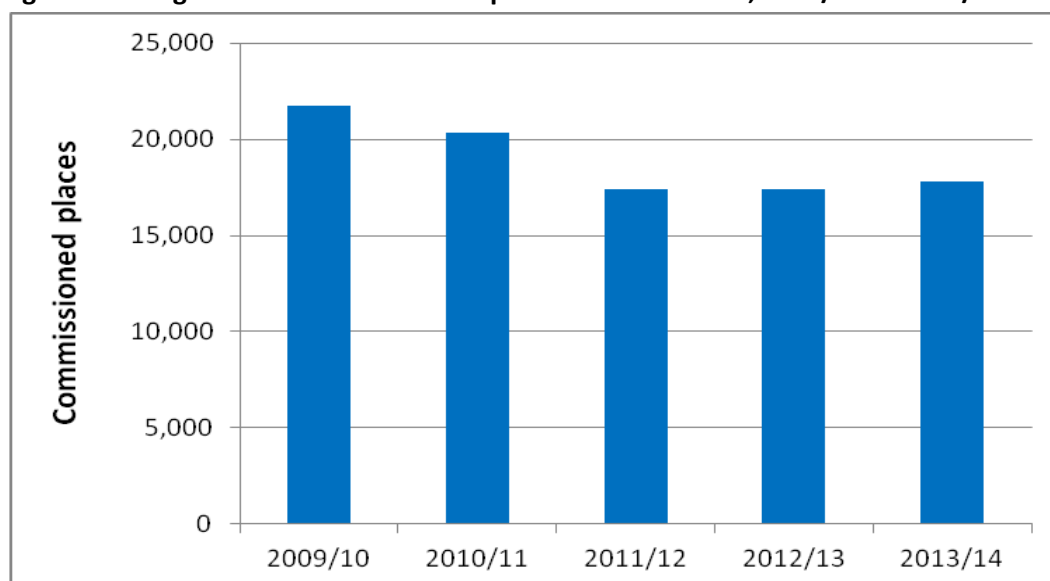
There are no published figures for attrition from nursing and midwifery courses in the UK. The only consistent data set available is for attrition from diploma courses in Scotland. These are defined as “the number enrolled (not those that start) against those that graduate (or are active with no outcome), regardless of transfers in and out”. Figure 17 shows that the overall attrition rate has fallen for the two most recent cohorts, dropping from a peak of 28.5 per cent in 2005/06 to 26.3 per cent in 2006/07 and 24.8 per cent in 2007/08.

Attrition rates vary by branch, from 39.1 per cent for learning disability nursing to 17.5 per cent for children’s nursing. The Nursing and Midwifery Student Recruitment and Retention Delivery Group suggests that strategies focusing on intervention and support around retention are having a positive effect on attrition.²⁸

The limited data available for England suggest that better screening of applicants and improved support are reducing attrition. According to Department of Health figures, the proportion of students dropping out by the end of the second year fell from 12.4 per cent for the 2008/09 intake to 8.3 per cent for the 2009/10 intake (note however that these figures are incomplete - they exclude the final year of study - and they do not cover universities in London).²⁹

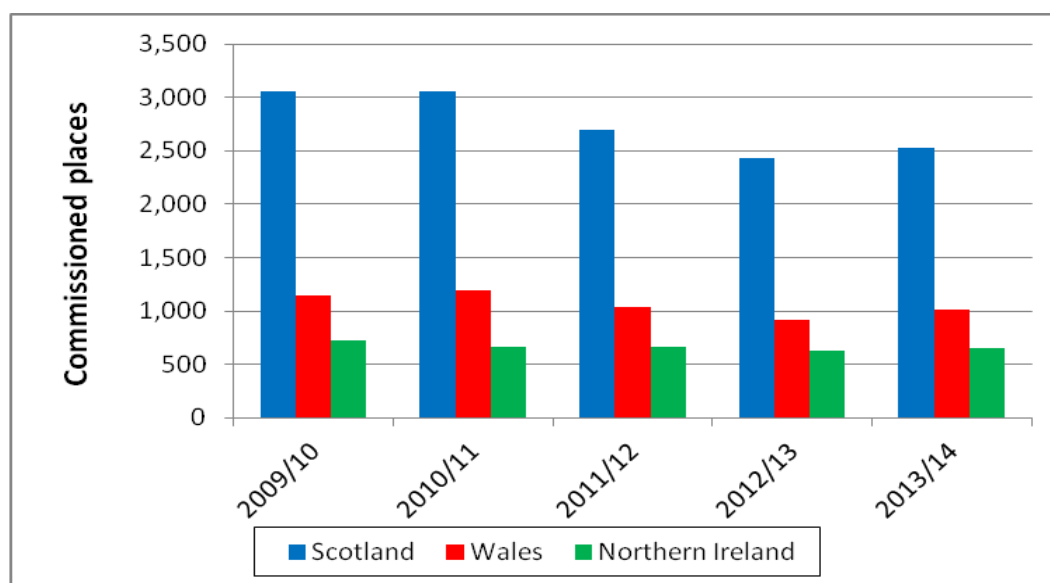
The Francis report recommended that student nurses should spend at least three months working on the direct care of patients before their degree course. The Government response proposed that student nurses should spend up to a year working on the frontline in order to receive NHS funding for their degree and suggested that this would have a positive impact on attrition rates. In May 2013 HEE proposed a pilot programme to see how best to take forward these proposals and to assess the impact on attrition rates.³⁰

Figure 18a: England: number of student places commissioned, 2009/10 to 2013/14



Source: Nursing Standard, vol. 27, no. 39, May 29 2013, pp12-13

Figure 18b: Scotland, Wales and Northern Ireland: number of student places commissioned, 2009/10 to 2013/14



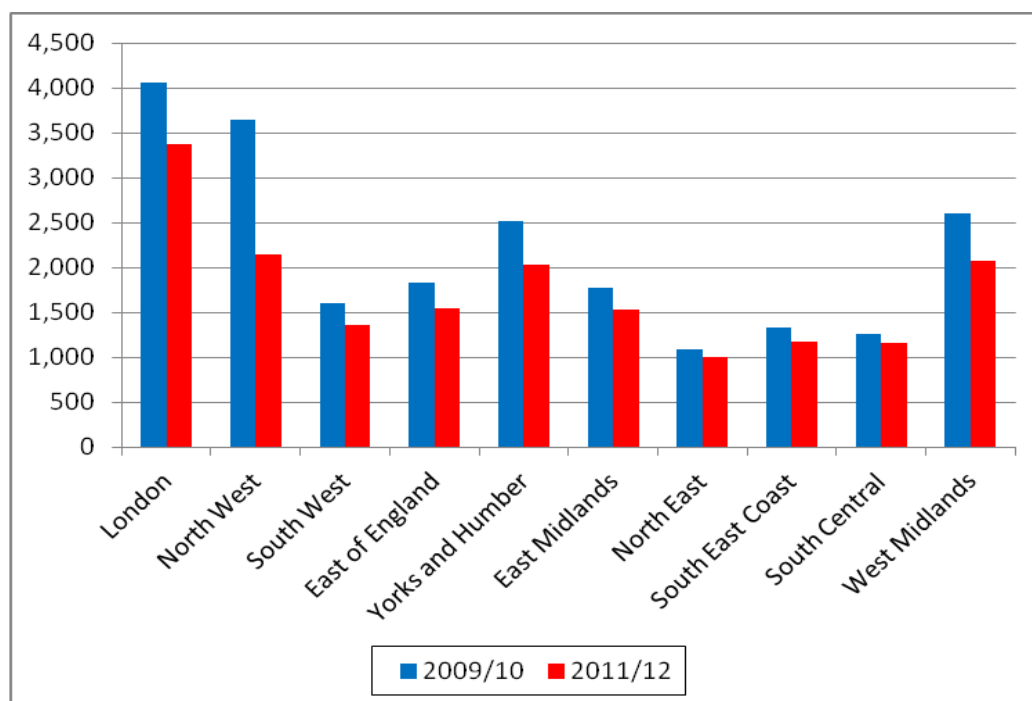
Source: Nursing Standard, vol. 27, no. 39, May 29 2013, pp12-13

The number of commissioned places shows small recovery in 2013/14

The numbers of places being commissioned is the key determinant to future intakes to education and subsequent labour supply. In 2012/13 there were approximately 21,379 places available across the four countries of the UK compared with 21,800 in 2011/12 and 25,285 in 2010/11. Overall, there are roughly 5,000 fewer places available now than in 2009/10. Figure 18a shows that the number of places lost in England since 2009/10 is about 4,340, while Scotland (630) and Wales (230) have seen a similar scale – approximately 20 per cent - of reduction, with a smaller loss (13.7 per cent or 99 places) in Northern Ireland (figure 18b).

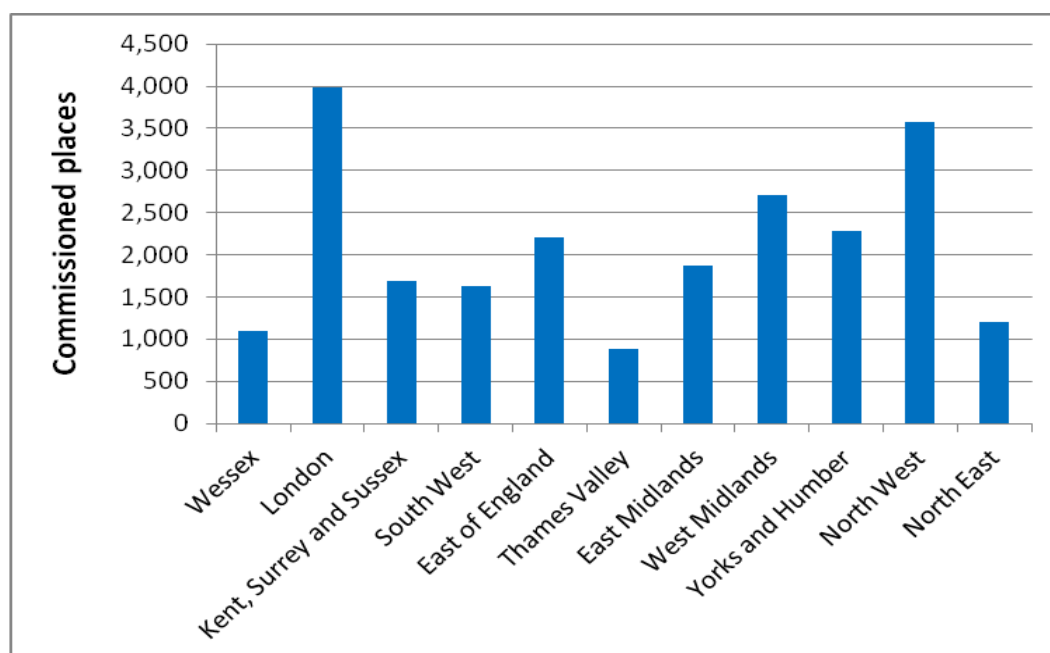
The latest available figures suggest that this trend will be reversed in 2013/14 with a 2.9 per cent increase taking the number of places up by about 613 to 21,992. Although almost two-thirds of this increase will be in England (up 391 places), proportionately larger gains will be made in Wales (10 per cent rise to 1,011), Northern Ireland (4.8 per cent to 655) and Scotland (4.1 per cent to 2,530) compared with a 2.2 per cent increase in England (17,796).

Figure 19a: England: number of student places commissioned, 2009/10 and 2011/12 by Strategic Health Authority



Source: *Nursing Standard*, vol. 27, no. 39, May 29 2013, pp12-13

Figure 19b: England: number of student places commissioned, 2013/14 by local education and training board (LETB)



Source: Nursing Standard, vol. 27, no. 39, May 29 2013, pp12-13

Figure 19a shows that the reduction in student places commissioned was not evenly distributed across the SHAs in England, with much larger reductions in Yorkshire and Humber (28.5 per cent) and London (26.6 per cent) compared with the North East (9.4 per cent) and South Central (10.1 per cent). Geographical areas in England are now broken down into areas (figure 19b). In some cases these differ from the former SHA areas so the figures for 2013/14 may not be strictly comparable with those for earlier years. The overall figure for England includes 2,536 places for midwifery and 2,803 for health visitors.

4. The Community Nursing Challenge

In this year's LMR we address, in particular, NHS community nursing. All four UK countries are placing a policy emphasis on shifting proportionately more care to community and primary care settings, partly due to the NHS funding constraints. There is nothing new about a policy focus on community-based care, but there is a growing recognition that any attempt at large scale transfer of services to community and primary care will require significant workforce change, and that current NHS community staffing levels may not enable this change to happen.

The NHS Centre for Workforce Intelligence (CfWI) conducted a 'horizon scan' on factors impacting NHS nurse supply and demand in England, which was published earlier this year.³¹ The CfWI report concluded that the demand for care would grow fastest in community care, and that the "nursing pool is not currently large enough to meet the need". It stressed that "The main nursing workforce challenge to 2030 will be to commission and make changes to the education and training system in order to create the necessary high level community nursing capacity at a pace that will meet demand."

In short, there is concern that there are insufficient nursing staff with community-based skills and training to support the implementation of a large scale transfer of services rapidly and safely. Concerns about staffing shortfalls are exacerbated by the knowledge, highlighted in Section 2, that the current NHS community-based nursing workforce is relatively old, with many only within a few years of retirement, and that there has been no sign of any recent overall growth in this part of the NHS nursing workforce. In this section we consider community nursing numbers and attempt to go beyond the general points made by the CfWI assess the scale of the likely shortfall.

It is not only the CfWI report that has drawn attention to the community nursing challenge. Several other recent reports and policy initiatives in all four UK countries have served to highlight that NHS community nursing requires a more sustained policy focus. The Queen's Nursing Institute (QNI) reported recently on the number of district nurses currently in training in England, Wales and Northern Ireland, and noted "widespread and significant concerns in the number of new District nurses currently being educated, particularly in England", concluding that "The numbers being trained are nowhere near the 'replacement level' required to maintain the District Nursing workforce, which has shrunk rapidly over the past ten years as experienced nurses have left the role, principally through retirement." The QNI reported that 21 per cent of district nursing courses in England did not run a cohort in 2012/13; at least 67 per cent of district nursing courses running in England in 2012/13 had 10 students or fewer on the programme and 13 per cent had only five students or fewer. This calls into question the viability of some of the courses on offer³². This also echoes the findings of the RCN's own report on the community nursing workforce in 2012³³.

HEE has been given the task of leading a range of work on district nursing in England, including "securing sufficient training commissions to deliver the service offer. Locally service and education commissioners, provider organisations and professionals will need to develop service and workforce plans to ensure high quality district nurses and teams for current and future services."³⁴

As noted in Section 2, in contrast to district nursing, NHS health visiting has been the focus of some Government attention in recent years. Staffing growth targets have been set in NHS England, and funding has been provided for more student places, and for a range of flexible retirement options

intended to improve retention rates³⁵. There has also been an RCN campaign in Scotland to support use of health visitors³⁶.

However, the trend in the size of the NHS community nursing workforce has followed that of the overall NHS nursing workforce – a tailing off of growth in recent years after increases in the period from 2002 to around 2008. With the exception of the funded growth in health visitor students, there is as yet no sign that this trend will be reversed, and the likely increase in retirements must also be considered.

Community nursing projections

Some sense of the scale of the workforce challenge for policymakers in both increasing significantly the amount of care provided in the community sector, and at the same time dealing with the ageing of the community nursing workforce can be illustrated by simple modelling. An assessment of community nursing stock and flows reveals the huge requirement to maintain the current supply of these nurses in the community sector, let alone to look at an increase in numbers.

Figures from the NHS Health and Social Care Information Centre show that, in September 2012 the NHS in England employed some 55,000 qualified nursing, midwifery and health visiting staff in community services (excluding community psychiatry, learning disabilities and school nursing). Approximately 43 per cent of these staff are aged 50 or over (this figure is based on the age profile of qualified community nursing and midwifery staff in NHS Scotland, from where more detailed age profile data is obtainable). The majority of these nurses might therefore be expected to retire over the next ten years.

In order to cover this expected retirement alone NHS community nursing services in England would need to recruit around 23,850 staff either by movement from the acute sector, returners, newly qualified or international inflow. Of course, not all those aged 50-54 will want, or be able to retire in the next ten years. If we assume that only half those currently aged 50-54 will retire, the replacement demand is about 17,150 over ten years. In addition, others in the community nursing workforce might be expected to leave by transferring to the independent sector, to agency nursing or GP practice nursing or to non-nursing employment or leaving paid employment altogether.

Detailed figures on 'wastage' from community nursing, particularly by age cohort, are not available but we know that overall wastage from nursing is running at about 8 per cent (including retirements) and we can assume that it is likely to be significantly lower from community nursing. Even with a very low 'wastage' rate, of say 2 per cent, this would add another 10,500 nurses to the 10 year requirement – just for the community nursing workforce to stay at current staffing levels. Putting these two figures together we can estimate a requirement of around 2,765 per year on average, over ten years.

If more services transfer from acute hospital to community settings, without substantial increases in productivity, then this demand will clearly increase much further. Currently around 22 per cent of qualified nursing staff work in community services. This proportion has increased very slowly, only by two percentage points, over the past ten years. If the target was for a very conservative five per cent point increase, in other words for community nursing to be around 27 per cent (70,000) of the total nursing workforce by 2022 (assuming that overall workforce does not increase) then a further

15,000 qualified staff would be required on top of the 27,650 identified above, bringing the total requirement to 42,700, or almost 4,300 a year.

While these are relatively crude assessments, using the limited publically available data, they do give some sense of the scale of the challenge. They reinforce the key point that, at present, there can be little confidence that the NHS will meet this replacement target, let alone be able to expand the community registered nursing workforce at any significant rate, unless there are policy changes.

In this context, it should be noted that international recruitment, which is reportedly to be used to boost health visitor numbers in NHS England through recruitment of staff from Denmark may be a 'quick fix' for policymakers, if the focus is on EU nurses with appropriate skills, but may not be sustainable.³⁷ High level international recruitments in the NHS in the last decade overshot national staffing growth targets as it was poorly co-ordinated with actual local staffing requirements.³⁸ The priority being given to health visitor numbers reflects the fact the only current specific national NHS staffing is for growth in health visitors. There is a risk that will distract attention from other equally critical elements in the NHS nursing workforce, notably community-based nurses whose focus will be on care of older people.

Policy solutions for the broader community nursing workforce are therefore likely to have to focus on re-skilling and redeploying current UK nursing staff, or directly recruiting and training more community nurses in the UK.

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